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AUTHOR Mehrotra, Santosh
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ABSTRACT

This paper examines the successes of 10 "high achievers," countries with social indicators far higher than might be expected, given their national wealth, pulling together the lessons learned for social policy in the developing world. The 10 countries identified are Costa Rica, Cuba, Barbados, Botswana, Zimbabwe, Mauritius, Kerala, Sri Lanka, Republic of Korea (South Korea), and Malaysia. The paper notes that their cultures, languages, and histories are varied, and that they have little in common, except in one crucial respect: they have all managed to exceed the pace and scope of social development in the majority of other developing countries. Their children go to school, and their child mortality rates have plummeted. The paper shows how, in the space of 50 years, these countries have made advances in health and education that took nearly 200 years in the industrialized world. Many of their social indicators are now comparable to those found in industrialized countries. The paper reviews UNICEF-supported studies which examined data on the evolution of social policy, social indicators, and public expenditure patterns in these countries over the 30-40 years of the post-colonial epoch. These studies pinpointed policies that have contributed to successes in social development, policies that could be replicated elsewhere. Contains 35 notes, 8 figures, 2 tables, and 46 references. (Author/BT)

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INTEGRATING ECONOMIC AND SOCIAL POLICY: GOOD PRACTICES FROM HIGH-ACHIEVING COUNTRIES

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Integrating Economic and Social Policy: Good Practices from High-Achieving Countries

SANTOSH MEHROTRA*

– October 2000 –

*Senior Economic Adviser, UNICEF Innocenti Research Centre

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The opinions expressed in this publication are those of the authors and editors and do not necessarily reflect the policies or views of UNICEF.

Abstract

This paper examines the successes of ten 'high-achievers' – countries with social indicators far higher than might be expected, given their national wealth – pulling together the lessons learned for social policy in the developing world. Some of them have immense populations, others small. Most are market economies, but one is not. Their cultures, languages and histories are varied. They have little in common, except in one crucial respect: they have all managed to exceed the pace and scope of social development in the majority of other developing countries. Their children go to school and their child mortality rates have plummeted. The paper shows how, in the space of fifty years, these countries have made advances in health and education that took nearly 200 years in the industrialized world. Indeed, many of their social indicators are now comparable to those found in industrialized countries. UNICEF-supported studies examined data on the evolution of social policy, social indicators and public expenditure patterns in these countries over the 30-40 years of the post-colonial epoch. The studies pinpointed policies that have contributed to their successes in social development – policies that could be replicated elsewhere.

1. Introduction

Within the last fifty years, most developing countries have made health and educational advances that took nearly two centuries in the industrialized countries (Corsini and Viazzo, 1997). Life expectancy has risen dramatically on average, as has the percentage of children going to school (UNDP, 1998). However, these significant achievements may not be immediately obvious given the scale of the task remaining to be accomplished.

Nearly 12 million children die every year from easily preventable diseases – two-thirds of them in Sub-Saharan Africa. Half a million mothers in developing countries still die every year during child birth. Some 183 million children still suffer from moderate and severe malnutrition – 80 million of them in South Asia.[1] Shockingly, half of all children born in South Asia suffer from moderate or severe malnutrition. Two in every five children in the developing world are undernourished.

Nearly one billion people in the world are illiterate. Despite the goal of universal primary education adopted in 1990, some 130 million school-age children (57 per cent of them girls), do not attend school – most of them in South Asia and Sub-Saharan Africa. Most of these are working children, many of whom are below age 10. A staggering one-third of all children in developing countries fail to complete four years of primary education, the minimum time period required for basic literacy and numeracy.

[1] These data are drawn from a UNICEF database.

Clean water, basic sanitation and a standard of living that allows families to meet their basic needs are still beyond the reach of billions of people in all parts of the world. Some 1.7 billion people are without safe water, of whom 600 million are in east Asia and the Pacific and almost another 300 million in Sub-Saharan Africa. Well over half of humanity is without access to adequate sanitation – 3.3 billion people – of whom 1.2 billion are in East Asia and the Pacific, and 850 million in South Asia. Moreover, these global numbers or averages barely begin to describe the real dimensions of deprivation and inequity in many countries.

Clearly, while progress has been made, much remains to be achieved in the vast majority of developing countries. This paper concentrates on ten developing countries that managed to exceed the pace and scope of social progress of most other developing countries. In fact, many of their social indicators are now comparable to those prevailing in industrialized countries. In order to understand why and how this social achievement was made possible, UNICEF supported the study of these ten countries – Costa Rica, Cuba and Barbados from Latin America and the Caribbean; Botswana, Zimbabwe and Mauritius in Africa; Kerala state (India) and Sri Lanka in South Asia; the Republic of Korea and Malaysia in East Asia (Mehrotra and Jolly, 1997).[2]

This paper attempts to pull together the lessons for developing countries from the experience of these high-achievers. The good practices discussed here clearly relate to health and education interventions. In other words, we were concerned with the health and education status of the population or the social dimensions of poverty – not income-poverty – though the latter issue is also analysed. Studies were carried out in each country by national teams – with high-achieving states selected in each region. The selection of countries was determined by the output or outcome indicators relating to health status, nutritional level, educational status, and to access to services. We were looking for countries which were high-achievers relative to their level of income – the selection was, in that sense, purposive. These were longitudinal studies – examining historical data on the evolution of social indicators, and their determinants (social policy and public expenditure patterns). They covered, in each country, a 30-40 year time period, spanning mostly the post-colonial epoch and the immediate pre-colonial period.[3]

The health transition and educational advances that took nearly 200 years to accomplish in the now industrialized countries were achieved within a generation or so in the selected developing countries. Many of their social indicators are now comparable with those of industrialized countries (see Table 1).

[2] These country cases are discussed in detail in Mehrotra and Jolly, 1997 (also paperback, Oxford University Press, 2000; see also *Le développement à visage humain*, Economica, Paris, forthcoming).

[3] African and Asian countries became independent after the second world war, while Costa Rica and Cuba had become independent of Spanish rule in the first quarter of the 19th century, though in Cuba the influence of the US was dominant until 1959. Barbados ceased to be a colony in 1938.

Table 1

	IMR[1] (1998)	Life expectancy (1998)	Primary Enrolment Ratio (gross) (1990-97)		Secondary Enrolment Ratio (gross) (1990-96)		Literacy rate		HDI***[3] (1997)
			Male	Female	Male	Female	Male	Female	
Costa Rica	14	76	108	107	48	52	95	95	0.801
Cuba	7	76	108	104	73	82	96	96	0.765
Barbados	13	76	90	91	90	80	98	97	0.857
Botswana[1]	38	61*	111	112	63	69	70	75	0.609
Zimbabwe[1]	59	56*	115	111	52	44	90	80	0.560
Mauritius	19	72	107	106	63	66	86	78	0.763
Kerala**	17	70	109.1	107.0	98.0	95.7	94.5	86.9	0.775*
Sri Lanka	17	73	110	108	71	78	98	96	0.721
Rep. of Korea	5	73	94	94	102	102	99	95	0.852
Malaysia	9	72	90	92	58	66	89	79	0.768
Industrialized countries	6	78	104	103	105	107	98**	96**	0.919
Low income countries 1996[2]	80	60	n.a.	n.a.	n.a.	n.a.	65	41	n.a.
Lower mid-income countries[2]	37	71	n.a.	n.a.	n.a.	n.a.	88	73	n.a.
Upper mid-income countries[2]	31	73	n.a.	n.a.	n.a.	n.a.	88	83	n.a.

Source: UNICEF, State of the World's Children 2000, except for * (Mehrotra and Jolly, 1997), ** (UNICEF, State of the World's Children, 1999) and *** (UNDP, Human Development Report, 1999).

Notes: 1. Life expectancy in Botswana fell to 47 years and in Zimbabwe to 47 years in 1998 (UNICEF, State of the World's Children, 2000) as a result of the impact of the AIDS pandemic; they were much higher in the early 1990s.

2. The Low Income Countries are: Sri Lanka, Kerala, Zimbabwe. The Lower-Middle Income Countries are: Costa Rica, Cuba, Barbados.
The Upper-Middle Countries are: Botswana, Mauritius, Republic of Korea, Malaysia.

3. IMR= Infant Mortality Rate (probability of dying between birth and one year of age per 1000 live births. HDI= Human Development Index.

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Drawn from three continents, this is a highly diverse group of countries – geographically, socially, politically and economically. Among them, there are small and large countries, island states and states that are land-locked. There are ethnically homogenous nations, as well as socially pluralist countries. There is a one-party state and many liberal democracies. There is one centrally planned economy but most are market economies. In other words, on the basis of their experiences one could argue that there are many routes to social development, low mortality rates and relatively high educational status – but we found that in many respects their social and economic policies were common. These policies are the subject of this paper.

All ten countries were low-income economies in the mid-20th century. Half of them have combined rapid economic growth with social achievement, and are now considered to have high-performing economies. Significantly, the high-growth economies achieved social progress very early in their development process, when national incomes were still low. Others grew more slowly and experienced interrupted growth. They demonstrate that it is possible to achieve a high level of social development (and mitigate the worst manifestations of poverty) even without a thriving economy, if the government sets the right priorities. Nevertheless, for that to be achieved, macro-economic policy cannot be divorced from social policy, since the former has an impact on social outcomes.

Sections 2 and 3 offer the policy lessons that emerge from an examination of these ten countries. Section 2 presents the characteristics of the macro-economic and social policy that can be derived from the experience of these ten developing countries. Section 3 examines their good practices in health and education. Section 4 addresses the question 'how income poverty fares in the high-achieving countries'. We avoided any discussion of the historical context, which made those policies possible. In other words, our interest was in 'how' health and education advance were achieved, not 'why' they were made possible.[4] Section 5 asks the question: "in which context do the good practices work, or in what kind of context are they not likely to function". The last section briefly assesses the potential for replication of these good practices in social policy to other areas.

2. Policy Lessons from High-Achieving States

▪ 2.1 *The role of public action and economic growth*

The first common theme that emerged from these very different countries was the pre-eminent role of the state in ensuring that the vast majority of the population had access to basic social services. This was the case regardless of whether the state in question was socialist Cuba or one that has been regarded

[4] The latter is an interesting question, but is really a question relevant to social history. It can only be examined individually for each country by understanding the configuration of social forces that led to the formulation of these policies. However, the configuration of social forces cannot be replicated, but policies can be.

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as the doyen of market-orientation – the Republic of Korea.[5] In other words, there was no reliance on a growth-alone strategy, nor faith in the trickle-down to the poor of the benefits of income growth. In principle, such trickle-down could indeed enable the poor to buy educational and health services – but that was not the assumption made by these countries – regardless of whether income per capita grew rapidly or not.

This is hardly surprising for anyone who takes a historical approach to the state's role in social policy in the now industrialized countries. Each of the European countries passed through a period of free trade and laissez-faire, followed by a period of 'anti-liberal' or social legislation or measures in regard to public health, education, public utilities, municipal trading, social insurance, and factory conditions. This was as true of Victorian England as of Bismarck's Prussia, of France during the Third Republic or the Empire of the Habsburgs. As Karl Polanyi puts it, "While laissez faire economy was the product of deliberate state action, subsequent restrictions on laissez faire started in a spontaneous way. Laissez faire was planned; planning was not". (Polanyi, 1944).

Specifically in the field of education, in the early 19th century learning became equated with formal, systematic schooling, and "schooling became a fundamental feature of the state," (Green, 1990). The classic form of the public education system, with state financed and regulated schools, with free tuition, and an administrative bureaucracy, occurred first in Europe in the German states, in France, Holland, Switzerland and the American North. All these countries had established the basic form of their public systems by the 1830s. Britain, the southern European states, and the American South, where the state took less action, were much further behind. But in each case the state was finally critical to the expansion of the system and the universalization of elementary education. As a consequence, most European countries saw a consistent rise in the literacy rate during much of the 19th century.[6]

Similarly, on health, before the late 19th century both governments and parents regarded serious illness and the ensuing mortality of infants and young children as inevitable. The first great successes of medical science contributed to creating a widespread awareness that many deaths were preventable, and public health programmes to address infant mortality were eventually started in earnest (Corsini and Viazzo, 1997). Such measures had a major impact on the infant mortality rate (IMR) in the industrialized countries from the late 1800s, and the decline in these rates has been dramatic ever since. The sharp drop in the 20th century was linked, in particular, to expanding maternal and child medical care, including pioneering efforts to establish local child health clinics, increase the number of babies born in hospital, and organize ante-natal clinics and neo-natal units.

[5] The Republic of Korea's success may have been touted by some (see World Bank, 1993a) as the result of market-oriented policies. This has been strongly disputed by others (see e.g. Amsden, 1992; Wade, 1990).

[6] For a more detailed discussion, see Mehrotra and Delamonica (forthcoming).

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There is an interesting question on how much general improvements in the standard of living helped to reduce infant mortality in industrialized countries. This historical question is still relevant to the present day problem of childhood mortality in developing countries (but also industrialized ones) and is posed by Preston and Haines, in their groundbreaking book, *Fatal Years: Child Mortality in Late Nineteenth-Century America* : "In 1900, the United States was the richest country in the world…On the scale of per capita income, literacy, and food consumption, it would rank in the top quarter of countries were it somehow transplanted to the present. Yet 18 per cent of its children were dying before age 5, a figure that would rank in the bottom quarter of contemporary countries. Why couldn't the United States translate its economic and social advantage into better levels of child survival?" Preston and Haines took the coexistence of high levels of child mortality alongside relative affluence as proof of the inadequacy of a thesis – which became very influential – proposed by the British physician and historical demographer, Thomas McKeown. This emphasised improvements in material resources as a causal factor in the reduction of mortality.[1] The inability of the US to translate economic growth into improvements in health status seems to imply that it was advances in medical sciences that did the job.

The question asked for the US could equally be asked for some developing countries. Why does Brazil, with many times the income per head of China and Sri Lanka, still have a *lower* life expectancy than the latter countries? The contrasts between some African economies, which experienced rapid economic growth are also telling. Between 1960 and 1993 Botswana managed to increase life expectancy for its population from 48 years to 67 years and Mauritius from 60 to 73 years. But why did Africa's most populous country, Nigeria, whose economy had grown at 9.7 per cent per annum over 1965-73, and thereafter experienced the windfall gains of the oil price increases, only manage to reduce its under-five mortality rate by less than 10 per cent (212 to 188) over three decades?

The answer lies in the role of public action. As Sen (1999) says, "The 'support-led' process does not wait for dramatic increases in per capita levels of real income. It works through priority being given to providing social services (particularly health care and basic education) that reduce mortality and enhance the quality of life." The contrast between the high-achievers and other developing countries is instructive in respect of the role of the state in education. For instance, primary education was the responsibility of the state in all the high-achievers from an early stage. On the other hand, there is evidence that the percentage of students enrolled in private schools in other developing

[1] McKeown (1976) argued that historically both therapeutic and preventive medicine had been ineffective, and that the reduction of infant mortality was primarily an economic issue. Thus, instead of investing money in sophisticated medical technology, perhaps even in public health measures, it seemed preferable to promote programmes capable of increasing the nutritional level of the whole population and enhancing the resistance of its younger members to the aggression of germs and parasites. Preston and Haines, however, suggested, on the basis of the lack of social-class differentials in child mortality in the US around 1900, that "lack of know-how rather than lack of resources was principally responsible for foreshortening life."

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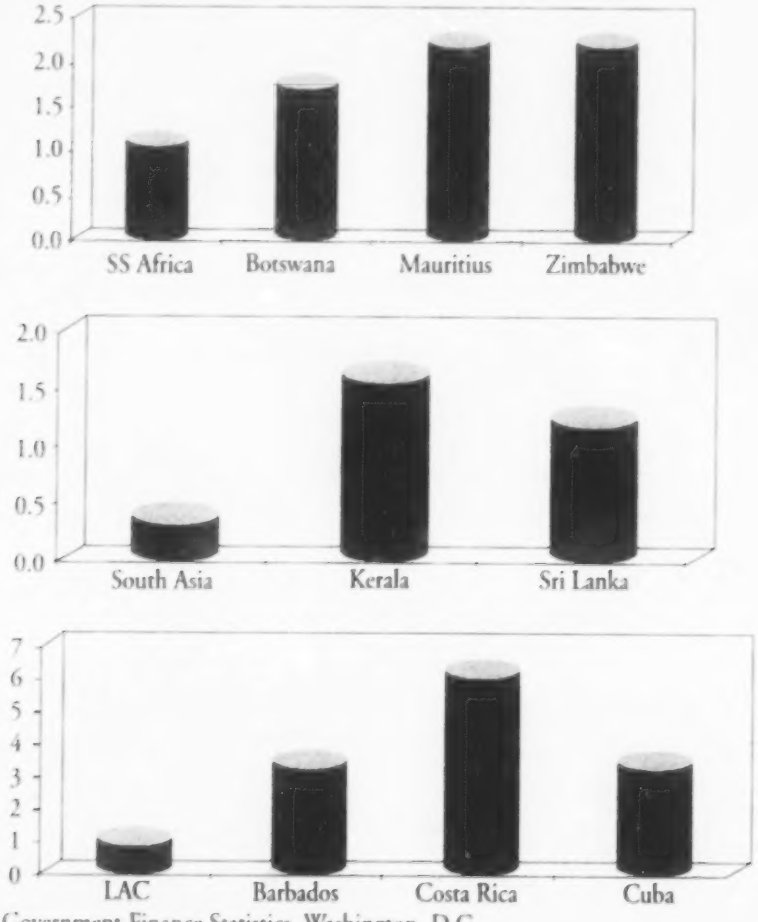
countries was not insignificant, especially in East and West Africa and in Latin America (Mehrotra, 1998).

▪ 2.2 *Spend on basic services*

In each of the high-achieving countries, the state's commitment to social development was translated into financial resources. Education expenditure as a proportion of GDP (1978-93) for each of our countries was higher for the high-achievers relative to the region to which they belong, without exception. For health too, the expenditures were higher than the regional average, except in the case of Korea.[8] In other words, the evidence suggests that the high-achievers gave higher macro-economic priority to health and education than the so-called low-achievers, as Figure 1 demonstrates.

While the ratios of expenditure give an idea of the macro-economic or fis-

Figure 1: *Health expenditure as % of GDP 1978-93*



Source: IMF, Government Finance Statistics, Washington, D.C.

[8] Republic of Korea did not have a public health system worth the name until 1976, and even then spending was relatively low. For a detailed analysis of the Korean case, see Mehrotra, et al., (1997).

cal priority accorded the population's health and education by governments, what matters at the receiving end is the absolute size of the expenditure in per capita terms. Relative to other countries in their region, the high-achievers were spending much more per capita than other countries (though some of it may be due to differences in per capita income). This is particularly so in education, and to a lesser extent in health as well. Thus in 1992 the median expenditure in education was $49 in East Asia, but $174 in Korea and $123 in Malaysia. The Sub-Saharan median was $11, but even a low-income country like Zimbabwe spent $26, while Botswana and Mauritius spent several times as much. Even though Costa Rica is not one of the countries with the highest per capita income in Latin America, it spent nearly three times as much per capita on education than the regional median ($43).[9]

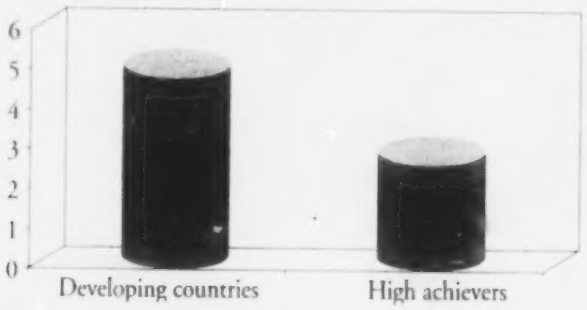
It may appear like a near tautology to argue that the state's commitment in the form of resources translated into high achievement. However, there were many other attributes or associated conditions of that commitment, quite apart from the quality and timing of the social investment (which are discussed later in this and the next sections).

The contrast between the high-achievers and the rest of the developing world (or 'low-achievers') with respect to defence expenditures is instructive. On average the defence expenditure in the high-achievers was lower than for developing countries (the average for the latter was 5%) for the period for which we have information (1978-93). Defence expenditure was not very significant in most of the high-achieving countries, except Korea (4-6 per cent of GDP) and Zimbabwe (6-8 per cent of GDP). In the case of Korea the potentially negative effects of the relatively high defence expenditure appears to have been offset by high economic growth rates. In Zimbabwe this was not the case; but high defence expenditure was necessitated by its geographical location as a frontline state against the former apartheid regime in South Africa, which destabilized the sub-region through the 1980s.[10] Like Zimbabwe, Botswana too was burdened by the destabilization of the sub-region by South Africa, and had a relatively high defence expenditure to GDP ratio (2-4 per cent), though this was somewhat eased by the state's rents from the mineral sector. In Sri Lanka, defence expenditure was very low until the mid-eighties, by which time significant social gains had already been made; from 1984 to 1986, it grew from 0.8 to 2.4 per cent of GNP onward because of the civil war conditions prevailing in the north and north-east of the country. However, in the remaining countries, defence was hardly any burden at all (Figure 2). Mauritius and Costa Rica do not have

[9] Since exchange rates influence the dollar value of these per capita expenditures, one should be careful in interpreting these numbers, especially for purposes of cross-country comparisons. However, the order of magnitudes seem to suggest that the differences noted in the text are real, especially when taken together with the differences in macro-economic and fiscal priority.

[10] In Zimbabwe, the tension resulting from unproductive defence expenditure and the commitment to provide social services to the poorest through the 1980s finally resulted in a decline in the capacity to sustain social services in the context of structural adjustment.

Figure 2: *Defence expenditure as a % of GNP*



Source: Mehrotra (1997a).

armies, while in Kerala there is almost no defence expenditure, given that defence is the responsibility of the central government in India's constitution.

▪ 2.3 *Adjustment with a human face*

Once made, the social investment was sustained by the high-achievers, in bad times as well as good.[11] The reaction of most developing countries, mainly in Africa and Latin America, to the economic crisis starting in the early 1980s and the structural adjustment that resulted, was to cut health and education expenditures (Cornia, Jolly and Stewart, 1987). However, government expenditure as a proportion of GDP was maintained in all the high-achievers through the 1980s. In Sub-Saharan Africa as a whole, health and education expenditure definitely declined in per capita terms and as a ratio of GDP in the vast majority of countries during adjustment between 1980 and 1993 (World Bank, 1994; Jayarajah, et al., 1996), but it held steady in Botswana, Zimbabwe and Mauritius. In Latin America too, health and education expenditure's share in GDP and in per capita terms was lower during adjustment than it was before adjustment, but in the high-achievers it remained stable. It appears, therefore, that the higher-than-average (relative to other countries in their region) macro-economic priority given to health and education expenditures by most of the high-achievers was sustained throughout the crisis years of the 1980s.

It is not just that most high-achievers protected social investment during times of economic crisis. When crisis forced a macro-economic stabilization and adjustment, the adjustment process was a relatively unorthodox one. This is particularly true of Korea, Malaysia, Mauritius and Costa Rica in the 1980s. In Korea, for example, inflationary pressures built up in the late 1970s as nominal wages rose faster than productivity. The state launched a phase of stabilization: it restrained its own budgetary expansion through 'zero-based budgeting', wage earners were urged to accept smaller wage increases, farmers were to accept fewer subsidies, businesses were to refrain from price increases, and

[11] UNICEF has often called this the principle of 'First Call for Children'.

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households were to spend less and save more. One reason why the government was able to make both capital and labour share the costs of adjustment was that income distribution was relatively equal in the country.[12]

Similarly, Costa Rica was a pioneer among Latin American countries in the sense that it was the first to show concern for the social cost of adjustment. Between 1980 and 1982, output declined, wages fell 40 per cent, and unemployment doubled. However, in 1982 a new government began to implement an unconventional stabilization process, maintaining public employment (through an employment subsidy), indexing wages, a business rescue plan to protect jobs – all part of a social compensation plan. The stabilization reduced the fiscal deficit, not only by reducing spending (as in most other countries) but also by increasing revenues (Garnier et al., 1997). This enabled the government to provide financial support for its social institutions. Thus, it was able to implement far-reaching adjustment measures without provoking the popular backlashes seen in other countries, such as Argentina, Brazil, the Dominican Republic, and Venezuela. This was because the cost had been evenly distributed among the country's main social groups.

In its own way, the transition that Cuba has been attempting since the early 1990s also contrasts strongly with the experience of the countries of Eastern Europe and the Commonwealth of Independent States, where the social costs of the transition to a market economy have been severe.[13]

On the other hand, in Zimbabwe, where the adjustment process in the 1990s has been much more orthodox, in keeping with the 'Washington Consensus', the social costs have seen a reversal in the 1990s of some of the social achievements of the 1980s (Loewenson and Chisvo, 1997).

▪ 2.4 *Allocative efficiency and equity in public spending*

It is both equitable and efficient in the health and education sectors to allocate public resources to the lower or primary levels of service. Prevention is cheaper than cure – hence it is cost-effective to allocate sufficient resources within the health sector to primary levels of care in order to prevent potential cases reaching hospitals. Such cases are dealt with more cheaply – for both the patient and the provider – at the primary health centre (PHC); the human cost is also lower, as care can be delivered easily due to the physical proximity of the PHC. It is equitable because a larger proportion of the population are likely to use a PHC; than a hospital - assuming the PHC is effective – since it is more likely to be physically accessible than most hospitals. Similarly, the social return to primary education is known to be higher than that for secondary/higher education

[12] It has been argued that, "the more equal the distribution of income economy-wide, the higher the quality of government intervention and, hence, the faster the rate of growth of manufacturing output and productivity." (Amsden, 1992).

[13] For an analysis of the social costs of the adjustment process, see UNICEF 1991;1992;1993; also Kaser and Mehrotra (1997). For a comparison with Cuba, see Mesa-Lago (1997); Mehrotra (1997c).

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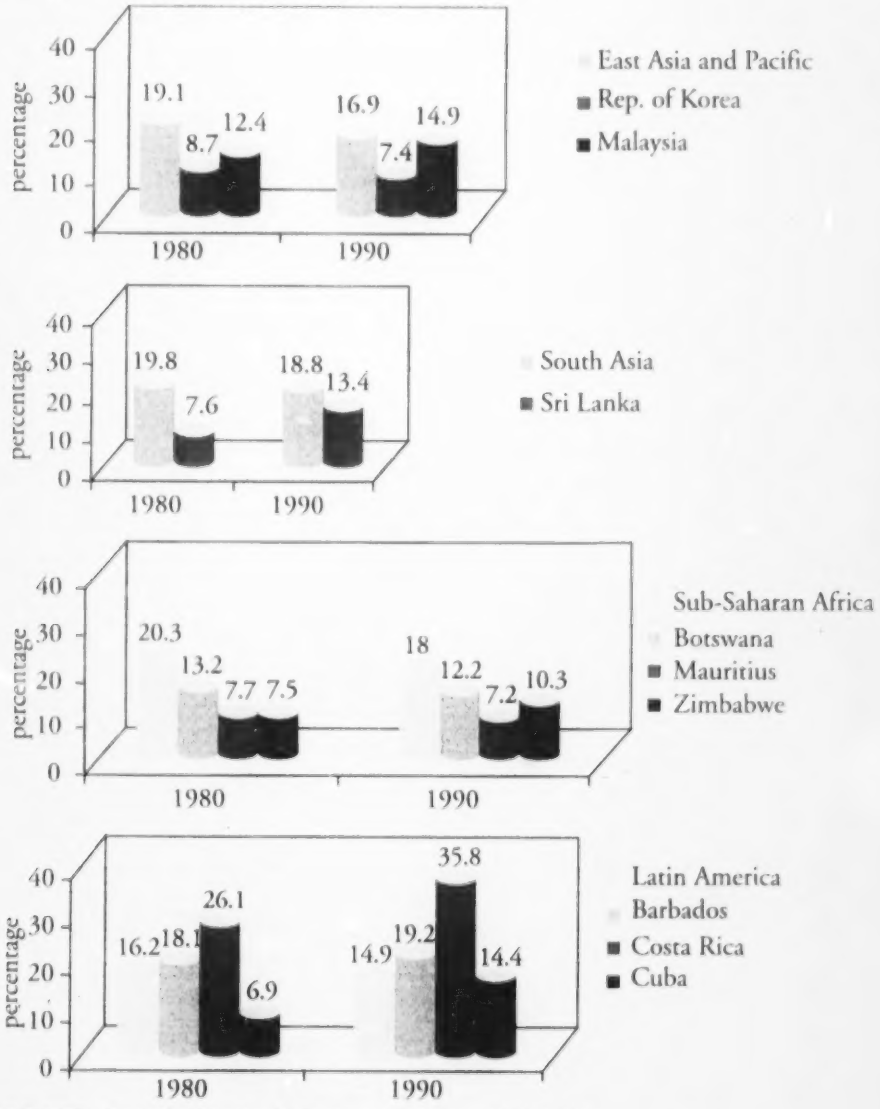
(Psacharopoulos, 1985); besides, in most developing countries, rarely do the poor manage to graduate beyond primary school, if that. Hence, it would be both allocatively efficient and equitable to meet the resource needs of primary education from the government budget on a priority basis.

A significant common feature about the expenditure pattern on education in the high-achieving countries was the efficiency and equity of allocation by level of education, compared to other countries in their regions. Equity may be a pre-requisite to ensuring essential inputs for schools. A comparison between the high-achievers (where primary enrolment is universal) and other countries, where education for all has not yet been achieved, shows some interesting contrasts, demonstrated in Figures 3 - 5.

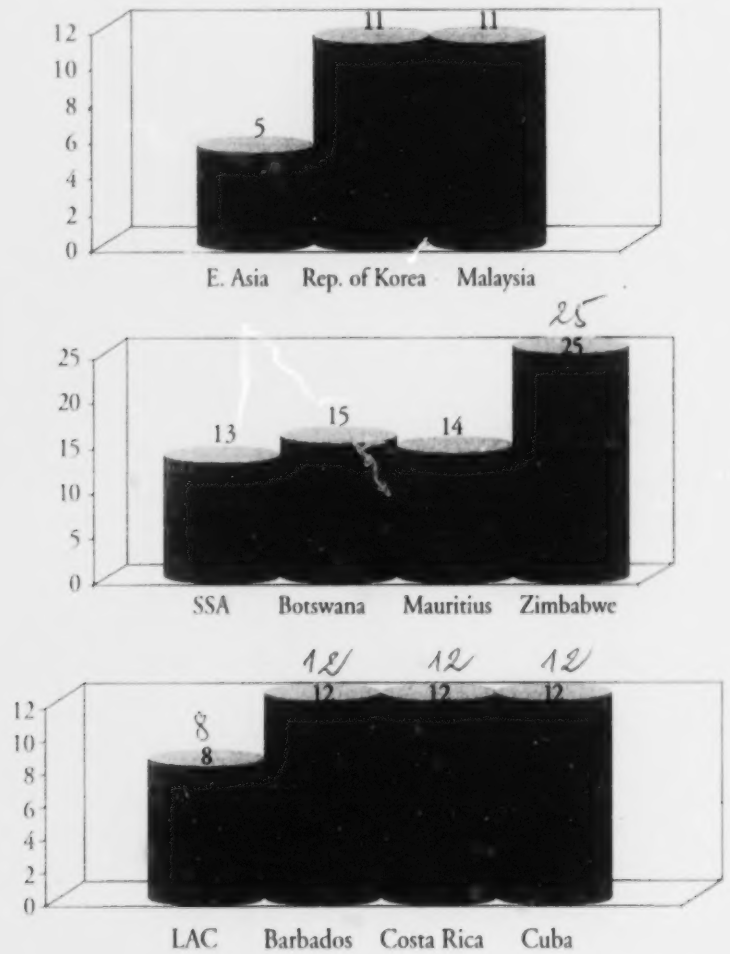
Figure 3: *Selected high achievers by geographuc region: higher education as a share of current government expenditures on education*



Source: UNESCO, Statistical Yearbook, Paris, various issues (1990-99)

First, there is a difference in the share of education expenditure allocated to higher education. With the exception of two of the Latin American countries, the high-achievers have tended to spend less than other countries in the region. This is particularly true for the earliest year for which we have data (1980), and was still the case in 1990. Second, there is a sharp difference in primary education expenditure as a proportion of per capita income, with the high achievers normally spending more than the regional average as Figure 4 shows.

Figure 4: *Primary per pupil expenditure as % of per capita income*



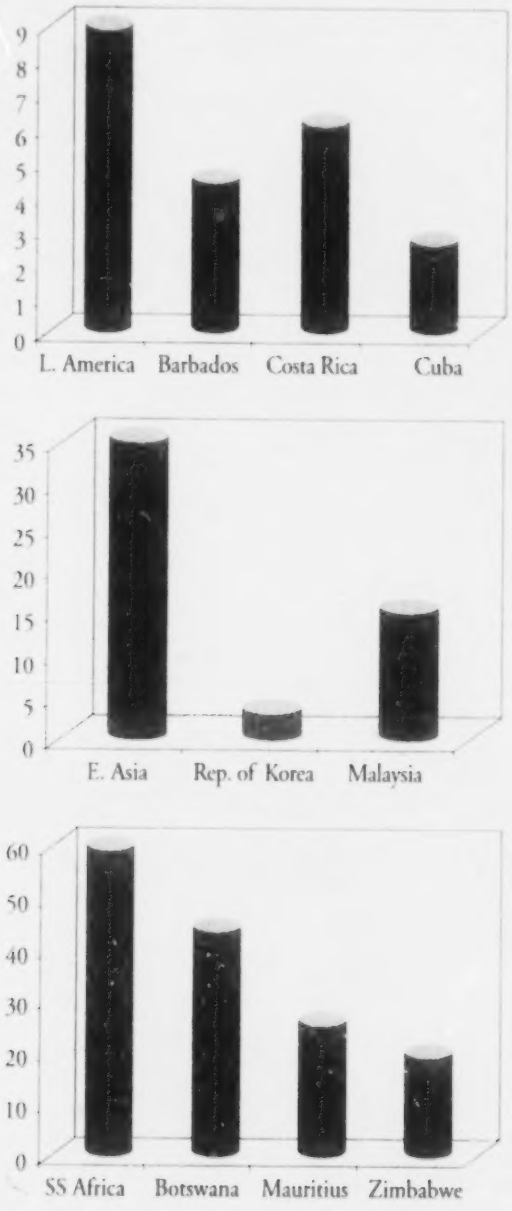
Source: UNESCO, World Education Report, Paris, 1993

Third, per pupil expenditures are also relatively equitable in the high-achievers as demonstrated in Figure 5. Per pupil expenditure in higher education as a multiple of primary per pupil expenditure is lower in all the high-achievers than in other countries in the region (Mehrotra, 1998).

While expenditures by level of education are readily available, it is much more difficult to find information on health expenditure by level (primary, sec-

ondary and tertiary), or type of service (preventive and curative).[14] There are, however, a few countries where information is available on the allocation of health expenditure to primary versus non-primary activities.[15] It appears that

Figure 5: *Per pupil expenditure is more equitable*



Source: Mehrotra (1997b).

[14] The primary level is the first level of care, usually a health clinic; the secondary level would usually consist of a district hospital, as a first-level referral centre, while the tertiary level may consist of a teaching or specialist hospital.

[15] This gap in information on public spending on basic social services will be filled in a forthcoming book, based on country studies carried out in over 34 developing countries. See Mehrotra and Delamonica (forthcoming).

Malaysia allocated one-fifth (in 1986-1990) and Barbados one quarter (in 1990-1991) of its health expenditure to primary health care activities, while Costa Rica's allocation in 1992 may have been about 10 per cent (Choon Heng and Siew Hoey, 1997; Bishop, et al., 1997; and Garnier et al., 1997). What is clear is that primary health activities (which have considerable overlap with preventive and basic curative services) are low-cost activities – and ones that do not absorb a very large part of public expenditure. It is the clinical activities, largely provided at the secondary or tertiary level, which are relatively more expensive (Joseph, 1985; World Bank, 1993).

Qualitative evidence from the selected countries indicates that emphasis was placed on primary health care in the organization of the health system; they also attenuated the urban bias in health services that had previously existed. All the countries succeeded in providing access to health services – in both physical and cost terms – in both rural and urban areas. Access to health services was nearly 100 per cent in urban areas for all the selected countries by the late 1980s, and in the range of 80 and 100 per cent in rural areas – not the case for other countries in their region. A universally available and affordable system, financed out of government revenues (with minimal out-of-pocket costs for users), functional at the lowest level, made effective by allocating resources at the lower end of the health system pyramid – these were the keys to an equitably-structured health system. This is in strong contrast to the pattern of intra-sectoral spending in most developing countries, where a significant proportion of the total health budget is spent on one or two centrally-located referral or teaching hospitals, while starving the primary health care system – despite the fact that the latter services the majority of the population.

▪ 2.5 *Educational achievement preceded high health status*

As regards the sequencing of social investment, the investment in basic education by the state preceded or was simultaneous with the breakthrough in infant mortality reduction (or public health expansion) – it did not post-date the breakthrough period. The synergies between interventions in health and education are critical to the success of each and increase the return to each investment – and the sequence is important.

In a comparison of decadal rates of reduction of IMR we define the 'breakthrough' period in IMR reduction as that decade during which the largest percentage decline in IMR took place. We found that high education indicators preceded the health breakthrough in our selected countries (see Table 2). These gave the selected countries a tremendous advantage over the others, since high education levels are closely linked to positive health improvements. When the investments in health infrastructure came, high educational levels ensured a strong demand and effective utilization of health services.

The most interesting example of this synergy between educational

health interventions comes from Korea. Before 1976 Korea had no publicly supported health system worth the name, and no form of broad-based medical assistance or medical insurance scheme. Health care was predominantly in the hands of private professionals, especially pharmacists. But its literacy rate was already 90 per cent in 1970. When the investment in public health came after 1976, IMR, which was still 53 in 1970 and 41 in 1975 dropped to 17 within a matter of five years (1980). Similarly in Sri Lanka, literacy levels were already 60 per cent before independence in 1948, higher than they are in (much larger and more populous) India and Pakistan today. Not surprisingly when health services expanded immediately after independence, Sri Lanka experienced a very rapid increase in life expectancy in the first decade of independence.

The point about this sequence of social investment is that the synergy between the interventions is triggered. The health interventions have more impact because they build upon a base of relatively high educational status in the population. The demand for the health services is greater, as is their utilization. For instance, Caldwell (1986) notes in an analysis of data from two

Table 2:

	Education Breakthrough Period	Health Breakthrough Period	IMR% reduction
Rep. of Korea	1960-70	1970-80	68
		esp 1975-80	58
Malaysia	1947-60	1960-70	40
		1975-85	50
Kerala	1956-60	1975-85	40
Sri Lanka	1947-60	1940-50	40
Botswana	1970-80	1980-90	37
Mauritius	Before 1950 (m) 1950-60 (f)	1945/9 – 50/4	40
Zimbabwe	1980-85	1980-90	30
Barbados	Before 1938	1950-60	50
	1970-80	1970-80	50
Costa Rica	Before 1960	1970-80	68
		1940-50	30
Cuba	1958-60	1970-80	40
		1975-85	50

Source: Mehrotra (1997b)

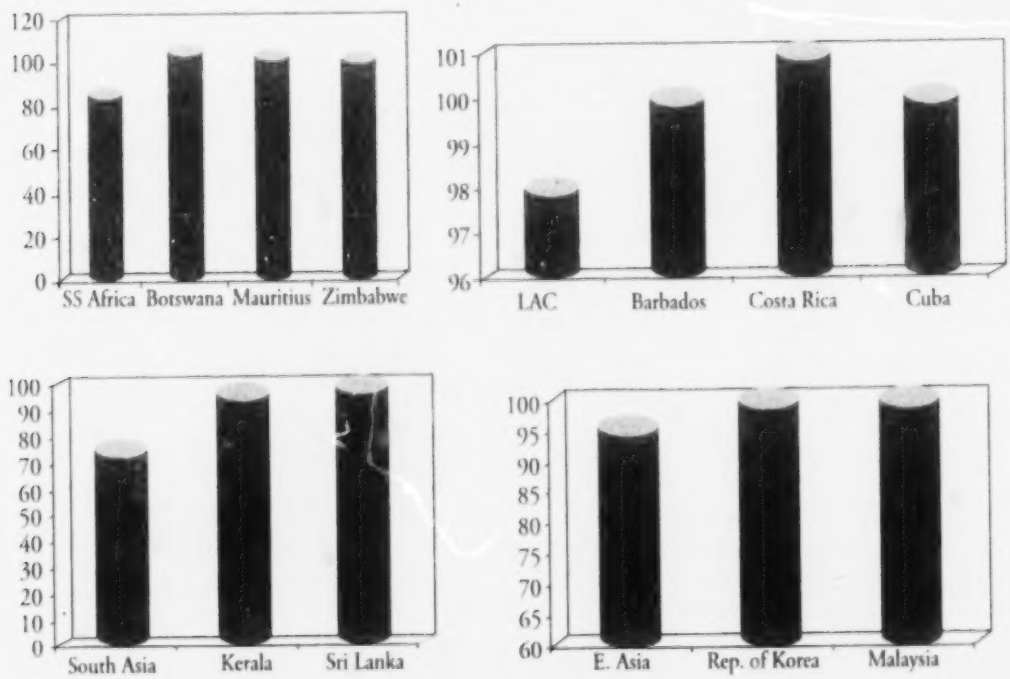
Nigerian villages, the equivalent gain in the expectation of life at birth was 20 per cent when the sole intervention was easy access to adequate health facilities for illiterate mothers, 33 per cent when it was education (as measured by mother's schooling) without health facilities, but 87 per cent when it was both, i.e., neither merely additive, nor multiplicative, but greater than either.

This notion of synergy can, in fact, be clearly understood by examining the life-cycle of an educated girl. An educated girl is likely to marry later, have fewer children, and provide better care for herself and her children than a girl without education. As more women become educated, there is a cumulative effect on more households with respect to fertility. As more households become smaller the provision of care improves for more children. Taken together, the benefits of greater education among women adds up to a virtuous circle of social development.

▪ 2.6 *The role of women's education and women's agency*

Underlying all the above characteristics – the quality, timing and sequence of investments in these countries – lies women's 'agency' role (Sen, 1995) i.e. the freedom women have to work outside the home, the freedom to earn an independent income, the freedom to have ownership rights, and the freedom to receive education.

Figure 6: W*omen 'agency': primary education (girls enrolled as a percentage of boys, circa 1990)*



Source: UNICEF, State of the World's Children, 1995

Health outcomes for children are not only the result of adequate food consumption and the availability of health services, but proper child-caring practices. In this respect the position of women in the household and in society, and the freedoms they enjoy, acquires major significance. Relative to other countries in their region, the selected countries were characterized by much greater access to education by women in the early stages of our period of analysis. In 1960 in the selected countries, female enrolment ratios at primary level were above the regional average (except in Malaysia). In 1970, female adult literacy rates were also higher than the regional average for all countries. By 1970, primary enrolment ratios were similar for males and females in all the selected countries, and substantial parity existed between males and females in secondary-school enrolment. In other words, any disparity in educational levels in terms of primary/secondary enrolment of men and women was completely eliminated by 1970 – in striking contrast to the large disparities that continue to exist to date in the vast majority of countries in Asia and Africa.

While education is an important determinant of women's position in society, there are other factors at play as well. Culturally, where there are no taboos attached to girls taking up roles outside the house, the task of setting up an effective health service becomes easier. In Sri Lanka and Kerala, where rural women have become educated, and where parents permit them to engage in work outside the home, it is easier to hire them as nurses or train them as midwives. Because they work in their own areas in their own language, they are accepted more easily by the community in house-to-house visits (Caldwell, 1986). In many parts of northern India (especially the Hindi-belt), the shortage of local recruits has meant the perennial under-supply of female health workers.

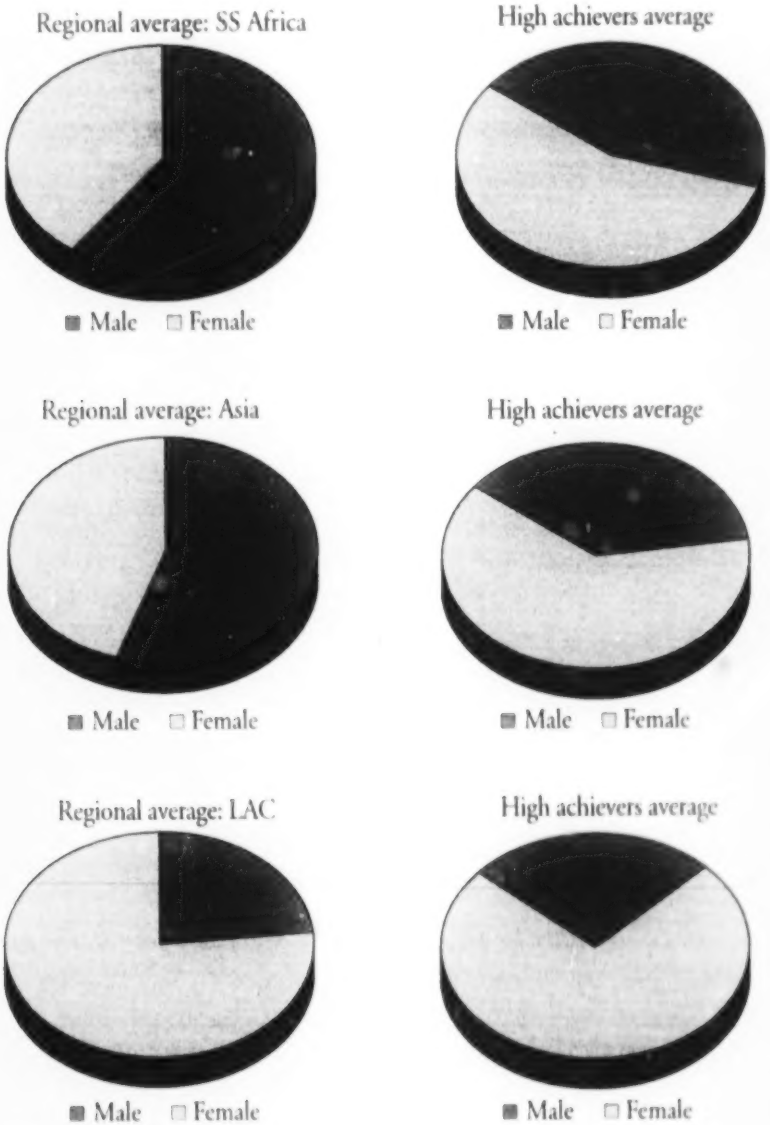
In schools the presence of female teachers has a positive impact on female enrolment. The proportion of female teachers in school is very high in the high-achieving countries (Figure 7). On the other hand, in most South Asian, Middle Eastern, and Sub-Saharan societies, there is a considerable male-female differential even in primary school enrolment, which in fact tends to worsen at the secondary level. Not surprisingly, many of the educational systems are characterized by a low proportion of female teachers in schools.[16]

If one examines the overall sectoral distribution of women's employment in the high-achievers, women, as a percentage of men in the workforce, are well represented in non-agricultural sectors of employment.[17] Non-agricultural employment is a better indicator than agricultural employment of the propen-

[16] Dreze and Gazdar (1998) find a similar contrast between the educationally backward state of Uttar Pradesh in India and the relatively advanced states of South India, and especially Kerala.

[17] If both agricultural as well as non-agricultural employment are included, the regional average in East Asia and Africa and even Latin America for female economic activity rate tends to be higher than in our selected countries, since agricultural work has traditionally been part of female economic activity. Hence, we particularly examined data on the non-agricultural employment of women.

Figure 7: *High share of female teachers in primary schools helps girls' enrolment*



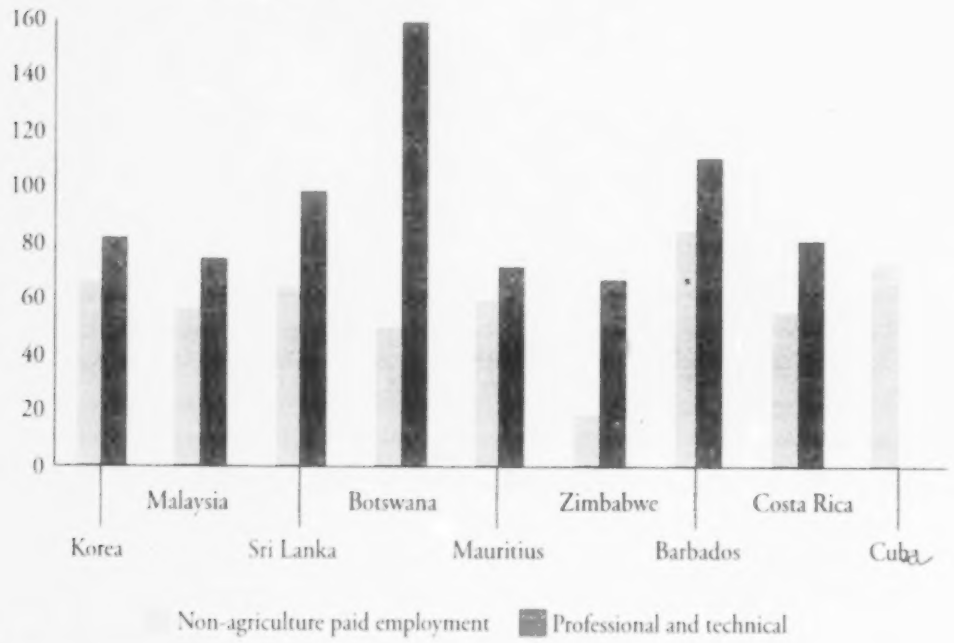
Source: UNESCO, Statistical Yearbook, various issues (1990-1999)

sities to work outside the home and of an independent source of income.[18] Because of the high educational levels achieved by women in the selected countries, women are nearly as well represented as men in the professional categories of employment. This is not to suggest that parity has been achieved with men even in these societies, but that considerable advances have been made.

In many of these societies the modern State has helped to strengthen the position of the woman in society. Nowhere is this more obvious than in Cuba.

[18] Agricultural sector employment will not givve women an independent income unless undertaken as wage labour, which is more likely to be undertaken within landless families by the male.

Figure 8: *Women's agency: employment outside the household, 1990 (women as percentage of men)*



Source: Mehrotra (1997a)

Many sections in Cuba's constitution explicitly refer to gender equality, and its penal code treats the infringement of the right to equal treatment as a criminal offence. In Zimbabwe changes in legislation have conferred majority status on women and now ensure inheritance and maintenance rights; women no longer need their husband's consent to buy immovable property, and law allows equitable distribution of family property between spouses upon divorce. In many of these respects Zimbabwe is quite unusual in Sub-Saharan Africa.

3. Systemic Operational Efficiency – the Essence of Good Practice in Health and Education Sectors

As we have seen above, in terms of allocative efficiency the fact that resources in the health system are spread relatively equitably throughout the pyramid of the health structure minimizes overall costs for a very simple reason – that prevention is cheaper than cure. Primary level services are largely of a preventive nature, and when they function well, they are actually used by the majority of the population, especially those who cannot afford private providers. A large number of hospital cases in developing countries could either be prevented or treated at much lower cost to the health system (and to the individual) had a primary health care system been functional – one that also provided basic curative care.

Similarly, despite the social rate of return to primary education to the soci-

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ety being higher than the return to higher education, governments in many developing countries have invested in higher education at the expense of primary schooling. In terms of allocative efficiency, the pattern of state investment should have been the other way round, leaving the investment in higher education to be made by families. As we have seen above, all the selected high-achievers ensured allocative efficiency through a pattern of state spending in the education sector – by placing emphasis on the lowest level of the education pyramid.

Even more important than the allocative efficiency is the technical efficiency in the use of resources invested at the primary level, i.e. obtaining the best results (outputs) from the use of given resources (or inputs), both financial and human.

The evidence from these countries in the primary education sub-sector suggests that unit costs per pupil should be kept low if the system is to expand in coverage without precipitous loss of quality. This is because education is, in most developing countries, one of the single largest categories in the budget, and in most countries the primary system accounts for half of that expenditure. In other words, unless costs are kept low it rapidly becomes almost impossible for the public exchequer to bear the burden of the rising recurrent costs as the system expands, particularly if quality is to be maintained.

Several methods were employed to keep costs low in the high-achieving countries in primary education. Zimbabwe offers useful lessons on how to expand the number of teachers – a dire need in most African and South Asian countries where there is a serious shortages of teachers. A four-year teacher-training course was introduced, with only the first and last terms spent in college. The rest of the time was spent teaching in the schools (Chung, 1993). The cost of training a teacher under this programme was less than half the cost of conventional training, and schools had teachers as enrolment expanded. Another mechanism used in Korea, Malaysia and Zimbabwe to reduce costs was to utilize existing facilities more fully by having double-shifts in schools.

Other means were also adopted to keep technical efficiency high. High repetition rates are a common feature of most primary schools in developing countries. High repetition often leads to drop-out by the repeaters. Both cause wastage of resources, and repetition places a limit on the number of school places available for new cohorts of children. Reducing this kind of wastage improves what is called 'internal' efficiency within the education sector.[19] One of the means adopted to reduce wastage and maintain internal efficiency was automatic promotion, practised in Korea, Malaysia, Kerala, Barbados, and Zimbabwe. Automatic promotion increases the number of years low-achieving students spend in school, and thus may increase learning. Given that it is known that spending at least four years in school is essential to retain literacy

[19] 'External' efficiency of the education sector refers to the absorption rates of graduates in the labour market.

and numeracy skills, this system ensures a minimum level of learning. Second, automatic promotion clears the backlog of repeaters in grades 1 and 2 (grades where much of the repetition is concentrated), creating space for new students. There could be problems, however, with such a system. If automatic promotion is implemented with no attempt to eliminate factors associated with school failure, problems of learning in the early grades may be passed on. There is a strong case for automatic promotion if accompanied by a minimum package of inputs, especially teacher training and materials.

Korea managed to keep costs low by maintaining a very high pupil-teacher ratio (early 1950s: 68; 1980: 48). High pupil-teacher ratios (normally high in most developing countries) combined with low teacher motivation and inadequate instructional materials cannot contribute to learning. However, in the selected countries adequate levels of financing for primary education ensured that teachers were not poorly paid, and funding for materials was available (Mehrotra, 1998). While maintaining low unit costs, minimum standards of quality were maintained in the high-achieving countries. While early on the ratio was relatively high, a situation forced on the country by the expansion of coverage, the pupil-teacher ratio has declined in all the selected countries. The decline in the pupil-teacher ratio would not by itself be an indicator of improving quality, unless repetition rates and drop-out rates were simultaneously low – which they are.

On the demand side, the reduction of costs to parents of sending children to school seems to have been a primary reason for the rapid expansion of primary enrolment in the selected countries. In all countries (except Korea) primary schooling has been entirely free of tuition fees. In many cases, even the indirect costs have been progressively reduced. By contrast, in many developing countries, out-of-pocket costs and user charges (and Parent-Teacher Association contributions) remain a barrier to enrolment for poor children and an incentive to drop out (Mehrotra and Delamonica, 1998).

Apart from private cost, another family-related factor that should be taken into account is the language of instruction. In the early years the mother tongue was used as the medium of instruction at the primary level in the high-achieving countries. Contrast this to the situation prevailing in most francophone and lusophone (Portuguese-speaking) African countries, where the colonial language is still the medium of instruction even in the earliest years of school.

Expanding girls enrolment and keeping them in school is the key to universal enrolment in South Asia and Sub-Saharan Africa. In the selected countries, the expansion of physical facilities and proximity to schools laid the basis for the participation of girls. Moreover, an important underlying factor was the high proportion of female teachers in schools in the selected countries (Figure 7). Female teachers give parents of girl-children a sense of security as well as providing a role model for girls in the community. In countries that are farthest from achieving 'Education for All' these good practices – low private costs,

mother-tongue instruction, female teachers – adopted by the high-achievers have tended to be overlooked.

What about good practices in the health sector? The high-achievers emphasized health-system building and a comprehensive (not selective) approach to primary health care. They achieved major reductions in the mortality of mothers and children by focusing their primary health care activities on mother and child health – thus applying the principles of the Alma Ata Declaration on Health (1978) long before the principles were written down.[20] Almost all children were born under medical attention, supported by good health referral systems. This was followed by household visits by the first-level health worker. High levels of immunization of children – provided mainly by primary health care centres - ensured that communicable diseases, which dominate the disease burden in any developing country, did not lead to high levels of morbidity or mortality for mother and child. Immunization coverage, which was high in these countries, is usually an indicator of a relatively effective formal health system that can reach a large proportion of the population. In the majority of the selected countries, immunization coverage had reached high levels long before the UNICEF-WHO campaign for universal immunization was launched in 1985.[21]

Primary health care is supposed to be delivered by first-level health workers acting as a team. Zimbabwe specifically trained a large number of community health workers. Sri Lanka relied heavily on the primary health midwife. In many societies, it is advantageous if these health workers come from the community in which they live, so that they have local support – as was the case in Kerala and Sri Lanka.

The first-level health worker should be able to turn for help to more highly trained staff. A serious problem facing most developing countries is that physicians and other health professionals trained at public expense have not been willing to work in rural hospitals or health centres. Malaysia ensured that all doctors trained at public expense were required to serve the public health system for at least three years. This allowed the government to post doctors to the rural areas. Sri Lanka would not permit the registration of doctors with the General Medical Council without requiring doctors to work for the government health service. This involved being posted out to rural areas.

Among the determinants of nutritional status, it is noticeable that most of the selected countries have a calorie supply at 120 per cent of requirements or above, which is a rough rule of thumb to offset for inequality of distribution among households. It is also higher than the calorie availability in other devel-

[20] At a major international conference held in 1978 in Alma Ata, the Kazakhastan capital, an important principle already in practice in many countries was internationally recognized in a declaration that the organization of the health system in developing countries be based on primary health services. The principle responded to the nature of the disease burden in developing countries.

[21] Thus, in 1982, the immunization rate was (as a percentage of 1-year olds): Korea 61, Malaysia 60, Sri Lanka 56, Botswana 63, Mauritius 94, Barbados 62, Costa Rica 81 and Cuba 99. Zimbabwe became independent in 1980 and had 75 per cent immunization coverage by 1986.

oping countries in the region. Second, as we have seen above, most provide geographical access to health services for a substantial part of their population, including immunization coverage. Immunization against measles reduces mortality from poor nutrition; and tetanus immunization also reduces child mortality. Third, maternal and child health services usually included surveillance of young-child growth (weight and growth-cards). Fourth, most high-achieving countries have safe water for most of their population – rarely the case in other countries in their region. They are also ahead on the provision of sanitary means of excreta disposal, except in rural areas of Sri Lanka, Kerala, and Zimbabwe. Diarrhoea, largely caused by infection from water and the environment, is a major cause of malnutrition; the typical growth curve dips below that usually found in industrialized countries at 4-6 months of age when the baby begins to crawl on the ground and to take foods complementary to breast milk (which makes access to safe water crucial).

In addition to the above factors, the provision of a nutritional floor in low-income countries (or those that have remained low-income countries because of lower per capita income growth) was found to be an effective mechanism of reducing protein-energy malnutrition. In three of them (Cuba, Sri Lanka, and Kerala) a system of food subsidies has been maintained from the 1960s to date. Fair price food shops (as part of a public distribution system providing essential commodities at below market prices) have existed in other states of India as well since the 1960s, but the point here is that in Kerala they are found in the rural areas, while they are effectively non-existent in the rest of rural India.[22] However, provision of the nutritional floor was one among a number of factors accounting for the low level of malnutrition in these countries, the others being better disease control through health services and women's control over resources.

In the majority of the selected countries, the health transition has been accompanied by a demographic transition. In fact, the country cases strongly suggest that it was non-family planning interventions – mortality decline and rising education, with rising marriage age and increased economic participation by women – that resulted in behaviour change in relation to fertility and ultimate decline of fertility. (Only in Korea is there evidence of a strong family-planning programme.) In other words, the demand for family planning services increased with the behavioural change in regard to fertility, which was in turn determined by factors that had little to do with family planning programmes. However, that does not mean that the supply of the means and instruments of family planning was unimportant – only that without an effective demand for contraceptive means, any conscious government-led family planning programme is unlikely to

[22] See Dreze and Gazdar (1998) for the contrast between the state of Uttar Pradesh, with a very high level of child under-nutrition, and the state of Kerala, in this respect. While 97 per cent of Kerala's villages had a fair price shop (part of the system of public distribution of essential commodities) in 1992-3, only 38 per cent of villages in Uttar Pradesh did.

be effective.[23] The inter-play between supply and demand for family planning is demonstrated by the fact that although all of the high-achievers have managed to reduce infant mortality rates below 20 per 1000 live births per year (except Botswana and Zimbabwe), those that have not raised contraceptive prevalence rates over 50 per cent (Malaysia, Botswana, Zimbabwe) still have population growth rates that are hardly declining. Hastening the demographic transition will require more than ensuring a health transition in some of these countries. However, in most of the selected countries the demand for family planning services followed the health/education breakthroughs. In fact, this pattern is consistent with the phenomenon in all industrialized countries, where fertility rates were very low before modern contraception was even around.

4. Income-Poverty in the High-Achievers

It is clear from the initial discussion in this paper that universal access to, and provision of, services was the guiding principle in the high-achieving states. In some ways, an equally interesting question in respect of these states, regarded as high-achievers in terms of social development (longevity and knowledge, two critical elements of human development), is how well they did in reducing income-poverty. In other words, while they certainly eliminated the social dimensions of poverty for the vast majority of the population, were they equally successful in reducing income-poverty?

We have information for incidence (or head-count ratio) of poverty for two points of time for most of the countries based on consistent national poverty lines. In Malaysia and Korea, overall poverty incidence declined to negligible levels. In Mauritius and Cuba, too, poverty declined significantly. However, in other countries, while there are downward trends, poverty has proved much stickier than might have been expected from the evidence on the health and education indicators.

In Sri Lanka, the headcount ratio for a low poverty line was 27 per cent in 1985-6, which fell to 22 per cent in 1990-1. Similarly in Kerala, while the incidence of poverty has declined from nearly 59 per cent of the population in 1973-4 to 32 per cent in 1987-8, it still remains high. Although information is less adequate about poverty incidence in Zimbabwe the unchanged distribution of wealth and slow economic growth suggests that the incidence of poverty has not declined. In Botswana too, it remains high, despite some decline. Thus, the very poor (those below the food poverty line) accounted for

[23] The contrast between the states of Uttar Pradesh (UP) and Kerala in India brings home the point. While the proportion of villages with medical facilities in 1981 in UP was ten, in Kerala it was 96, with a similar contrast in 1991 between the number of births taking place in medical institutions. In other words, in Kerala health centres provided family planning services as part of overall health care – and the total fertility rate was 3.9 in 1981 and less than 2 in the mid-90s. On the other hand, the few health services in rural UP concentrated on family planning campaigns, especially female sterilization, often using force. The total fertility rate was 5.9 in 1981 and has stagnated since (5.1 in 1991) (Dreze and Gazdar, 1998).

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41 per cent of all individuals in 1985-6, and in 1993-4 they still made up 30 per cent of the population.

In Costa Rica and Barbados the incidence of overall poverty may have worsened somewhat during the 1980s, as it did in much of Latin America. In Costa Rica, the proportion of households below the poverty line was stagnant in the 1970s, but increased sharply in the urban areas in the 1980s, while it fell somewhat in rural areas. In Barbados, working on the basis of an international poverty line of $1 per day, the incidence of poverty in urban areas was negligible (4.9 per cent in 1980 and 2.3 per cent in 1989), but increased sharply in urban areas (from 10.5 to 21 per cent).[24]

Thus while all these countries became high-achievers in terms of health and education status early in their development process when per capita incomes were still low, they have shown much less progress in terms of income-poverty alleviation – with the exceptions of Korea, Malaysia, Mauritius and Cuba.

The factors underlying the greater resistance of income-poverty vary. In the South Asian cases, slow economic growth has remained a barrier. Kerala experienced landownership reform that was much more effective than that in the rest of India (Jose, 1985). Communist party governments in Kerala alternated with the Congress party in state elections, and the effect of competitive electoral politics was to bolster the social agenda. However, because of slow economic growth in the state, incomes have not risen much. Sri Lanka had a landownership pattern much more equitable than that prevailing in most parts of the Indian subcontinent, and, until the 1970s at least, economic policies were also relatively egalitarian – becoming much less so in the 1980s. All of these factors, taken together with relatively slow growth in income, prevented a sharp decline in the incidence of poverty. In other words, social policies conducive to health and educational development and equitable wealth distribution are not sufficient conditions for successful income-poverty reduction; equitable income growth is a necessary condition.

An unequal distribution of assets and income in the African cases seems to be a contributory factor in the persistence of poverty. Zimbabwe had been through a revolutionary liberation war against racist white rule, and liberation fervour carried over into social policies. However, in regard to landownership, the government's hands were tied for a decade by the terms of the agreement between the erstwhile white regime and the winners of the liberation war. In addition, most industry remained in the hands of the white owners after independence, and the income distribution is simply a reflection of the unequal distribution of assets in the economy. The lack of economic growth over the 1980s compounded the problem of poverty. In Botswana, income-poverty appears to have proved stubborn because of wealth distribution despite rapid economic growth in a resource-rich economy. In a primarily agrarian economy, with a large proportion of the population dependent on agriculture, the ownership of

[24] Income distribution has been relatively equitable in Barbados; together with relatively good economic growth, poverty levels have remained low.

land and cattle (an important source of wealth in this country) is highly unequal. Nevertheless, the Botswanan government has succeeded in using its diamond rents to invest in the health and education of the population.

In Costa Rica, the persistence of poverty is also the result of unequal land ownership and inequality in income distribution. The distribution of land remains highly inequitable even by Latin American standards, and in 1988, 44 per cent of the rural population was landless (IFAD, 1992). Income inequality is a further contributory cause: the ratio of the income of the top 20 per cent of the population to the bottom income quintile is 12.7 (not much below Zimbabwe 15.7 and Botswana 16.4) (World Bank, 1995).

Thus, while high levels of social indicators are common to all the selected countries, this does not necessarily translate into a uniformly high level of human development (a composite index of income, longevity and knowledge). Only a few of them (Korea, Malaysia, Mauritius) come out well in terms of all three kinds of desirable outcomes – economic growth, income-poverty reduction and social development. Others fail, to a lesser or greater degree, on one or even two other counts (i.e. income growth or poverty reduction).

5. In What Context Do Good Practices Function?

Methodologically, the approach in this section is quite different from that in sections 2 and 3. In those sections we looked at the concentration of various characteristics among the high-achievers, and compared them with the concentration of the same characteristics among the low-achievers. In this section we attempt a much more difficult exercise. Here we search for the concentration of underlying reasons for success – 'causes' if you will – among the high-achievers.[25]

The role of ideology and politics cannot be ignored as driving forces behind public action in the selected countries. Thus, in Cuba, as in all other developing centrally planned economies (eg Vietnam is another good example), communist ideology was the driving force behind state action in not only reducing poverty, but also providing equitable access to health and education services to all. In Kerala, the process began during colonial times in the independent royal state of Travancore-Cochin, partly as a response by the local king to missionary activity. After independence, however, which is when most of the social development occurred, the process was driven by the competitive elec toral politics between the Communist Party and the populist Congress Party. In Sri Lanka, public action stemmed from the combined influence of socialist

[25] An alternative method could be followed – at least in theory. We could, for instance, have looked at the incidence by each characteristic (rather than the concentration of a characteristic among the high-achievers). In other words, we would have looked at the percentage of all countries with certain characteristics that are high-achievers compared to the percentage of high-achievers among all countries. However, there are several methodological problems with such an approach. The search for characteristics across countries is, essentially, a qualitative matter, and estimating percentages (or incidence) in quantitative terms may raise questions about differences of the degree to which a characteristic is present in a given country – questions that are impossible to answer.

ideology, competitive electoral democracy and Buddhism (characterised by the tenets of equality of all human beings and compassion for all living beings).

In Costa Rica it was essentially a social-democratic consensus in a democracy that has lasted almost 150 years, with elections every four years, in strong contrast to the rest of Latin America. Similarly, in the island states of Mauritius and Barbados, it was competitive electoral politics that drove the state's interest in health and education services. Both island states have a tradition of electoral democracy based on the parliamentary system.

Likewise, Botswana's political history since independence has been rather exceptional by African standards (Duncan, et al., 1997). As in other African countries, independence was preceded by a multiparty election and Western-style constitution, but it is unusual in that these were retained after independence. The political process in Botswana has been for the most part democratic, with regular free elections and a range of political parties both within and outside parliament.[26] In Zimbabwe, social development came more as a natural consequence of the liberation struggle; and the country has maintained a democratic framework within a one-party dominant state. During the liberation struggle, new forms of social organization emerged that encouraged popular participation under the auspices of the liberation movements. After independence, popular participation was mobilized and channelled by party and central-government programmes and structures.[27] While both Botswana and Zimbabwe have a tradition of regular democratic elections, both have remained one-party dominant states.

Cuba is a one-party state, while Malaysia and Korea (at least during the relevant historical period) have been one-party dominant states. But even in Cuba and Malaysia there has been scope for a public 'voice' in the governance process. Social mobilization by the cadres of the communist party, especially by women's groups, was a key element of social progress in Cuba.

In Malaysia social development was the outcome of the state's attempt to correct the social and economic disadvantage of the Malay population based on ethnicity. The dominant political party in Malaysia has indeed governed through a coalition of parties, the other parties being essentially representative of the two other major ethnic groups (Chinese and Indian).[28] In Korea, early social devel-

[26] Botswana politics are indeed dominated by the Botswana Democratic Party, which has won every election since 1964. The domination of the BDP seems to reflect the popular will, in that it has consistently won an absolute majority of the vote.

[27] Over the 1980s and 1990s, this increasingly shifted to more bureaucratic forms of participation in response to central government policy.

[28] A New Economic Policy was introduced after the race riots of 1969. The Policy was based on a strategy of gradually redistributing wealth from growth rather than outright expropriation of the ethnic minorities. The indigenous Malay population, which lived mainly in rural areas, was targeted to own at least 30 per cent of the corporate wealth (companies with shareholders funds above Malaysian Ringit 2.5 mn were to allocate 30 per cent equity to Malays) and a similar proportion of modern-sector employment by 1990. To speed up Bumiputra participation in the commercial sector, the government set up state enterprises that provided employment opportunities at every level. Small and medium non-Bumiputra enterprises were basically unaffected by this law and left to grow (Leong and Tan, 1997). The 20-year time frame, gradual approach, and presence of escape routes for non-Bumiputra businesses helped to limit ethnic animosity towards the policy.

opment was driven by a military state (supported by the USA) facing a communist 'threat' from the north; once set in motion the process was sustained by an authoritarian state committed to economic growth. In other words, 'voice' in governance was a key element of success in all states except Korea.

It is important to emphasise here the distinction we have tried to draw above between 'democracy' and 'voice'. Democracy has, unfortunately, come to mean many things to many people. In fact, despite the considerable increase in the number of states that became democratic in both Latin America and Sub-Saharan Africa during the 1980s and early 1990s, there is no systematic evidence that they are more progressive than the non-democratic states that preceded them.

That suggests that democracy – in the conventional sense of regular multi-party, free and fair elections – is neither a necessary, nor a sufficient condition – but it helps. What is critical, however, is that there has to be a mechanism for the expression of the voice of the people.[29]

The form of popular representation is one question. Another is whether a particular structure of the organization of production is a necessary condition of ensuring longevity and knowledge for the majority of the population. It is noticeable that only one high-achiever was a centrally planned economy – Cuba. Of course, there are other developing countries with centrally planned economies that have achieved health and education levels far superior to that achieved by developing market economies at the same level of per capita income, e.g. Vietnam, Mongolia, and the Central Asian states during the Soviet period. In fact, among the small number of developing countries in the post-war, post-colonial period that have been centrally planned, it is remarkable that such a high proportion of them managed to achieve social indicators well above those for other countries in the same income bracket.[30]

In fact, almost all countries with centrally planned economies achieved social indicators far better than might be expected by their level of per capital income.[31] In that sense, the percentage of all countries with central planning that were high-achievers compared to the overall percentage of high-achievers among all countries is much higher. However, with the end of central planning as we knew it – whether mandatory or indicative – and the shift in the dominant policy paradigm, the notion of now introducing centralized planning is a non-starter.

In fact, selected high-achievers were market economies. Given that the vast majority of developing market economies in their region were unable to match their improvements in social indicators, the lessons from the high-achievers are particularly relevant for these market economies. Moreover, while

[29] On the role of 'voice' in improving the health sector, see Mehrotra and Jarret (2000).

[30] If countries like Laos and Cambodia did not achieve significant improvements in social indicators, for instance, a large part of the explanation must lie with the long-term effects of the war in Indo-China lasting over two decades – and the continuing internal conflict even after 1975.

[31] For an analysis of social achievement in three centrally planned economies (Vietnam, China, Cuba) see Ghai (1997). The paper is based on case studies for UNRISD on these three countries, plus Sri Lanka, Kerala, Costa Rica and Chile.

central planning may be unfashionable, we have demonstrated earlier that the role of the state in these market economies in ensuring universal access to basic services was paramount.

Another critical issue is whether economic growth is a necessary condition of social development. We have already discussed above (section 2.1) how all the selected countries made substantial improvements in their health and education indicators early in their development process, when incomes were still low. They all started as low-income countries. While some have graduated to become middle-income countries, many of them (Cuba, Zimbabwe, Kerala, Sri Lanka) have remained low-income countries, having experienced limited economic growth.

In these slow-growing economies, while quantitative indicators of health and education status have not been affected adversely, the quality of services does seem to have been affected. Thus relative economic stagnation – in Sri Lanka, Kerala, Zimbabwe, and (in the 1990s) Cuba, has created problems for the social sectors. In Sri Lanka, food subsidies and free health and education services were made possible by heavy taxation of export plantation crops – tea, rubber, and coconut. When international commodity prices dipped in the late 1950s and the 1960s, and the balance of payments deteriorated, it became increasingly difficult to sustain those expenditures. Nevertheless, because of the political difficulty of cutting social expenditures and the food subsidy, the government continued to heavily tax the plantation sector, and jeopardized the plantation industry (Alailima and Sanderatne, 1997). Quite clearly, the economy needs to generate a surplus for social investment (as the plantation sector did), but excessive surplus extraction may lead to lower economic growth, ultimately causing a curtailment of social expenditures.

Kerala offers similar lessons – though for rather different reasons. Kerala ranks ninth among the 25 states of India in terms of per capita income and has had one of the lowest levels of industrialization. At the same time, trade unionism is common not only among industrial and public sector employees as in other parts of India, but, unlike the rest of India, among agricultural workers. It has even spread to the informal labour sector – all aided by the high levels of literacy. One outcome of unionization is that Kerala has the third highest wage rate for agricultural workers in the country (after the bread-basket states of Punjab and Haryana), and Kerala is the only state where real wages have nearly doubled between 1960 and 1990. The result has been that the little industry that existed has tended to shift to neighbouring states, and agricultural output has been declining because it is cheaper for the state to import its food from the rest of India (Krishnan, 1997). The overall result is that the economy has been practically stagnant since 1975. The scope for increasing public expenditure in order to improve quality of services has been limited by slow growth.

Similarly, Zimbabwe's per capita income growth was slightly negative (0.2 per cent) over the 1980s. Hence the concern in the 1990s has shifted from the social policy, distribution and equity concerns that dominated Zim-

babwe in the 1980s to aggregate growth and balance-of-payments concerns. The adoption of a structural-adjustment programme has also limited social expenditures, and there has been a rise in IMR and maternal mortality as real health expenditures shrank and fees were introduced for health services (Loewenson and Chisvo, 1997).

Clearly then, sustained improvements in the quality of services will require increased per capita expenditures, especially if the population is still growing. Increased per capita social expenditures - whether private or public - may be difficult to sustain in the absence of per capita income growth. In the absence of sustained increase in per capita social expenditures, the quality and quantity of services is likely to be impacted adversely. However, economic growth does not automatically get translated into improvements in health and education status. The example of oil-rich countries like Cameroon, Venezuela, Gabon and Nigeria demonstrated that windfall gains (from oil-price increases in the 1970s) can be wasted, while Brazil's example shows that the fruits of rapid economic growth (e.g. in the late 60s and 70s) may not be shared equally.

Turning to another possible explanation of the success of social policies in the high-achievers, an argument could be made that one reason for their success was their relatively small size – in terms of territory or population – and hence their manageability in terms of the scale and magnitude of problems facing policy-makers. While this argument may possibly hold for two of the cases that are island states (Barbados and Mauritius), it is hardly valid for the remaining countries. Large populations are not typical for developing countries – there are no more than 15 developing countries with populations larger than 50 million – and the vast majority of these smaller states have social indicators that are worse than those in the high-achievers. The population size of the selected countries exhibits considerable range and is comparable to the population of most other countries in their region. Malaysia has 20 million people, while Korea has 45 million people – only Indonesia has a population in the East Asia region that is significantly larger than Korea. In South Asia, the relevant comparison is not with countries per se, but with states within countries, which usually have similar populations. Kerala (30 million) and Sri Lanka (18 million) have populations comparable to those in a province of India or Pakistan.

Zimbabwe's population (10 million) is larger and Botswana's (1.4 million) smaller than that of the average African country. A small minority of African countries have a population exceeding 10 million (Nigeria, Ethiopia and South Africa among them). Among the Latin American cases, Costa Rica has a population similar to those found in Central America; Barbados is not very different from other Caribbean island states, and Cuba's population is that of a median population for countries in Latin America. Clearly then, to the question: is a small population size a necessary condition for rapid improvement in health and education in a developing country, the answer must be no.

A final point: could it be argued that ethnic homogeneity is a necessary

condition for the state to potentially follow polices which promote human development? It has been argued, for instance, that one reason why Botswana was able to successfully pursue human development policies was that, more than any other country in Africa, it is dominated by one ethnic group – the Batswana. It could also be argued that ethnic divisions are not an issue in Korea or Cuba. However, most countries among the high-achievers had racially or linguistically mixed populations – Malaysia, Sri Lanka, Kerala (with its caste conflicts), Zimbabwe, Mauritius or Costa Rica. Clearly, conflict between linguistic or racial groups is a complicating factor, but these countries have demonstrated that there are policy instruments at hand to allow skilful handling of those conflicts.

One can see from the preceding analysis that it is difficult to establish any common characteristics as providing reasons for success: neither the organizational form of the government, nor organizational form of the economy, nor geographic size, nor social composition. However, in the earlier sections we did establish some commonality or good practices in economic and social policy.

6. Summary and Reflections on Replicability of Good Practices

We derived five principles of good social policy, and a number of good practices, based on the experience of the high-achieving developing countries. However, before we summarize them, we need to note the over-arching principle which provided the foundation for the development strategy: these countries did not give priority to achieving economic growth or macro-economic stability first, while postponing social development.[12] The high-achievers demonstrate that it is possible for countries to relieve the non-income dimensions of poverty, and achieve social indicators comparable to those of industrialized countries, regardless of the level of income. The poor should not have to wait for the benefits of growth. We do not downplay economic growth but, for the "Washington Consensus", per capita income growth is a predominant part of the strategy, since proponents of the Consensus believe "there is no general tendency for distribution to worsen with growth" and that "distribution remains stable over long periods of time" (Deininger and Squire, 1996). We have seen, however, that there are plenty of historical cases of episodes of economic growth that have not translated into improvements in health and education status.[13] We have argued

[12] This is one respect in which our conclusions differ from those of the Washington Consensus. Leading researchers in the World Bank suggest that "economic growth typically promote[s] human development, and a strong positive relationship is evident from the line of best fit (the 'regression'). It is acknowledged that there are deviations (the 'residuals') around this line; these are cases with unusually low, or unusually high, performance in human development at a given level of income or a given rate of economic growth." (Ravallion, 1997). They argue that the human development approach – espoused in the current paper – devotes "more attention to residuals" and the "regression line is ignored".

[13] Cornia (2000) argues that the Deininger and Squire formulation is highly questionable in any case. In an analysis of 77 countries he demonstrates that income inequality has worsened in 45 countries.

elsewhere (Taylor, Mehrotra and Delamonica, 1997) that broad-based poverty-reducing growth has rarely occurred on a sustained basis in the absence of the universal availability of social basic services.

The five principles of good social and economic policy we derived are:

1. The pre-eminent role of public action, regardless of whether it took place in a centrally planned economy or a market economy. The experience of the industrialized countries from a comparable period of development offers the same insight.
2. While the level of social spending is important for health and education outcomes, the equity of the intra-sectoral spending pattern matters even more.[34] The social investment was also protected during times of economic crisis as well as structural adjustment.
3. Efficiency in the utilization of human and financial resources needs to be practised if social spending is not to become a burden on the state exchequer. A number of specific good practices in both health and education sectors ensured both allocative and technical efficiency in resource use.
4. There seemed to be a sequence of social investment: educational achievement preceded, or took place at the same time as the introduction of health interventions. The separate sectoral interventions had a synergistic impact on health, educational and nutrition status of the population, i.e. the sum of their impact was greater than the effects of the individual interventions.
5. Women were equal agents of change, and not mere beneficiaries of a welfare state.

Underlying each of these principles were specific good practices of social policy. We found that the worst manifestations of poverty – preventable child deaths, the powerlessness of illiteracy and debilitation of ill-health – were relieved in the selected countries for almost the entire population. However, with the exception of Cuba, Mauritius, Korea and Malaysia, income-poverty remained more stubborn, although it certainly declined in most of the ten selected countries. Where income-poverty has been resistant, the pace of economic growth has been relatively slow. In fact, if there is one over-arching principle emerging from the historical experience of the high-achievers, it is that there is little prospect of the synergy between economic growth, income-poverty-reduction and health/education advance being realised without integrating macro-economic and social policy. If economic growth is the dominant objective with macro-economic policy determined first (with the Ministry of Finance in the lead) – with social policy trailing behind – this synergy cannot take place.

What is the potential for replication, and what kind of general insights

[34] The level of social spending is often determined by such unproductive expenditures as defence (which we found is generally low in the high-achievers) and external debt servicing (of particular significance today in the Highly Indebted Poor Countries).

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can be learned about processes taking place? What does it take to transfer the specific good practices to other areas? We suggest that economic growth is a necessary condition of *sustained* improvement in health and education indicators and in the quality of social services, but it is neither a necessary nor a sufficient condition for the 'take-off' in social development.

The harder issue to resolve is what kind of political system (as opposed to political commitment) is most conducive to the replication of these good practices. While 'voice' in the decision-making process is a pre-requisite, the more difficult question is how that voice is articulated. Clearly, a democratic system alone is not sufficient, though we found that it was definitely helpful. [35]

The only general insight that we can safely draw is that the causes and driving forces behind social success were historical, and very specific to the country in question. The social forces that combined to produce the revolutionary changes within a matter of decades in these high-achievers can be understood in a national context, but can hardly be replicated. Social forces cannot be conjured up, nor can any amount of social engineering help to create them. Policies, however, can be replicated. Hence this paper has focused on those social policy principles and good practices that any state would need to adopt in order to address some key elements of human development in developing countries.

[35] That it is not sufficient becomes clear from a contrast in the social indicators between two states in India: West Bengal and Kerala. Both have had regular elections to the state legislature and both have a long tradition of multi-party politics. For over twenty years, West Bengal has had a government of the Left Front, of which the dominant member is the Communist Party of India (Marxist). While this government has done much to secure the tenancy rights of small-holder tenant farmers (which are extremely insecure in other non-Communist ruled states in India), the health and education indicators in the state are not much better than in the poorest states of northern India's Hindi belt (Sengupta and Gazdar, 1998). Kerala, on the other hand, is a high-achiever in terms of social indicators, as we have seen. Perhaps the fact that the Communist Party in West Bengal has hardly faced any serious opposition, and has been continuously in power for over 20 years may explain some of this difference. In contrast, in Kerala, the electoral competition between Left Front governments and the Congress has led to each party internalising the social agenda.

References

Alailima, P. and Sanderatne, N. (1997), 'Social Policies in a Slowly Growing Economy: Sri Lanka' in Mehrotra, S. and Jolly, R. (eds.).

Amsden, A.H. (1992), 'A Theory of Government Intervention in Late Industrialisation', in L. Putterman and D. Reuschenreyes (eds.), *State and Market in Development; Synergy or Rivalry?* Lynne Rienner Publishers, Boulder, Colorado, and London.

Bishop, M.D., Corbin, R.. and Duncan, N.C. (1997), 'Barbados: Social Development in a Small Island State' in Mehrotra, S. and Jolly, R. (eds.).

Caldwell, J.C. (1986), 'Routes to Low Mortality in Poor Countries' in *Population and Development Review*, 12/2.

Choon Heng, L. and Siew Hoey, T. (1997), 'Malaysia: Social Development, Poverty Reduction, and Economic Transformation' in Mehrotra, S. and Jolly, R. (eds.).

Chung, Fay (1993), 'Educational Expansion, Cost Considerations and Curriculum Development in Zimbabwe' in Jill K. Conway and S.B. Bourque (eds.), *The Politics of Women: Education Perspectives from Asia, Africa and Latin America*, University of Michigan Press.

Cornia, A. (2000), 'Inequality and Poverty in the Era of Liberalisation and Globalisation.' Paper presented at the UNU Millenium Conference "On the Threshold: the United Nations and Global Governance in the New Millenium", Tokyo, 19-21 January 2000.

Cornia, G.A., Jolly, R., and Stewart, F. (1987), *Adjustment with a Human Face*, Oxford University Press, Oxford.

Corsini, C.A. and Viazzo, P.P. (1997), *The Decline of Infant and Child Mortality: The European Experience: 1750-1990*, Martinus Nijhoff Publishers, The Hague.

Deininger, K. and Squire, L. (1996), 'A New Data Set for Measuring Income Inequality', *World Bank Economic Review* 10 (3):565-91.

Duncan, T., Jefferis, K., and Molutsi, P. (1997), 'Botswana: Social Development in a Resource-rich Economy' in Mehrotra, S. and Jolly, R. (eds.).

Dreze, J. and Gazdar, H. (1998), 'Uttar Pradesh: The Burden of Inertia', in J.Dreze and A. Sen (eds.), *Indian Development. Selected Regional Pespectives*, Oxford India Paperback, New Delhi.

Garnier, L., Grynspan, R., Hidalgo, R., Monge, G. and Trejos, J.D. (1997), 'Costa Rica: Social Development and Heterodox Adjustment' in Mehrotra, S. and Jolly, R. (eds.).

Ghai, D. (1997), 'Social Development and Public Policy. Some Lessons from Successful Experience', UNSRID Discussion Paper 89, Geneva.

Green, A. (1990), *Education and State Formation: the Rise of Education Systems in England, France and in the USA*, St. Martin's Press, New York.

IFAD (1992), *The State of World Rural Poverty*, Geneva

Jayarajah, C., Branson, W., and Sen, B. (1996), 'Social Dimension of Adjustment. World Bank Experience, 1980-93', World Bank Operations Evaluations Study, Washington, D.C.

Jose, A.V. (1985), 'Poverty and Inequality: The Case of Kerala', in A.R. Khan and Eddy Lee (eds.), in *Poverty in Rural Asia*, ILO-ARTEP, New Delhi.

Joseph, S. (1985), 'The Case for Clinical Services', in Scott B. Halstead, Julia A. Walsh, and Kenneth S. Warren (eds.), *Good Health at Low Cost*, Rockfeller Foundation, New York.

Kaser, M., and Mehrotra, S. (1997) 'The Central Asian Economies since Independence' in Allison, R. (eds.) *Challenges in the Former Soviet Union*, Brookings Institution Press, Washington, D.C.

Krishnan, T.N. (1997), 'The Route to Social Development in Kerala: Social Intermediation and Public Action' in Mehrotra, S. and Jolly, R. (eds.).

Loewenson, R. and Chisvo, M. (1997), 'Rapid Social Transformation despite Economic Adjustment and Slow Growth: the Experience of Zimbabwe' in Mehrotra and Jolly (eds.).

Mehrotra, S. and Jolly, R. (eds.) (1997), *Development with a Human Face*, Clarendon Press, Oxford.

Mehrotra, S., Park, I., and Baek, H. (1997), 'Social Policies in a Growing Economy: the Role of the State in the Republic of Korea' in Mehrotra, S. and Jolly, R. (eds.).

Mehrotra, S. (1997a), Social Development in High-Achieving Countries: Common Elements and Diversities', in Mehrotra and Jolly (eds.).

Mehrotra, S. (1997b), 'Health and Education Policies in High-Achieving Countries', in Mehrotra and Jolly (eds.).

Mehrotra, S. (1997c), 'Human Development in Cuba: Growing Risks of Reversal', in Mehrotra and Jolly (eds.).

Mehrotra, S. and Delamonica, E (1998), 'Household Costs and Public Expenditure on Primary Education in Five Low Income Countries: A Comparative Analysis', in *International Journal of Educational Development*. 18(1) pp. 41-61.

Mehrotra, S. (1998), 'Education for All: Policy Lessons from High-Achieving Countries' in *International Review of Education*, Volume 44, Issue 5/6, pp. 461-484.

Mehrotra, S., and Delamonica, E., (forthcoming) *Basic Services for All? Public Spending and the Social Dimensions of Poverty*, UNICEF.

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Mehrotra, S., and Jarrett, S. (2000), 'Improving Health Services in Low-Income Countries: A 'Voice' for the 'Poor'', *Social Science and Medicine.*

Mesa-Lago, Carmelo (1997), 'The Social Safety Net in the Two Cuban Transitions', in *Transitions in Cuba: New Challenges for U.S. Policies*, Florida International University, Cuban Research Institute.

Polanyi, K. (1944), *The Great Transformation: the Political and Economic Origins of our Times*, Reinhart, New York.

Preston, S.H. and Haines, M.R., (1991), *Fatal Years: Child Mortality in Late Nineteenth Century America*, Princeton University Press, Princeton, NJ.

Psacharopoulos, G. (1985), 'Returns to Education: A Further Update and Implications', *Journal of Human Resources*, 20/4.

Ravallion, M. (1997), 'Good and Bad Growth: The Human Development Reports' in *World Development*, Volume 25, issue 5, pp. 631-638.

Sen, A. (1995), 'Agency and Well-being: The Development Agenda' in Noeleen Heyzer with Sushma Kapoor and J. Sandler, *A Commitment to the World's Women – Perspectives for Development for Beijing and Beyond*, UNIFEM, New York.

Sen, A.(1999) 'Investing in Health', General Keynote Speech at 52nd World Health Assembly, May 1999.

Sengupta, S. and Gazdar, H., 'Agrarian Politics and Rural Development in West Bengal' in J. Dreze and A. Sen (eds.) *Indian Development. Selected Regional Perspectives*, Oxford India Paperbacks.

Taylor, L., Mehrotra, S. and Delemonica, E., (1997), 'The Links between Economic Growth, Poverty Reduction and Social Development: Theory and Practice', in Mehrotra and Jolly (eds.).

UNDP (1998), *Human Development Report 1998*, New York.

Wade, R. (1990), *Governing the Market: Economic Theory and the Role of the Government in East Asian Industrialisation*, Princeton University Press.

World Bank (1993a), *The East Asian Miracle*, Washington, D.C.

World Bank (1993b), 'Investing in Health', *World Development Report*, Washington, D.C.

World Bank (1994), *Adjustment in Africa: Reforms, Results, and the Road Ahead*, Oxford University Press, Oxford.

World Bank (1995), *World Development Report*, Oxford University Press, Oxford.

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INTEGRATING ECONOMIC AND SOCIAL POLICY: GOOD PRACTICES FROM HIGH-ACHIEVING COUNTRIES

This paper examines the successes of ten 'high-achievers' – countries with social indicators far higher than might be expected given their national wealth. Their progress in such fields as education and health offers lessons for social policy elsewhere in the developing world. Based on UNICEF-supported studies in each country, the paper shows how, in the space of fifty years, these high-achievers have made advances in health and education that took nearly 200 years in the industrialized world. It pinpoints the policies that have contributed to this success – policies that could be replicated elsewhere.

UNICEF Innocenti Research Centre
Piazza SS. Annunziata, 12
50122 Florence, Italy

Tel.: +39 055 203 30
Fax: +39 055 244 817
E-mail (general information): florence@unicef.org
E-mail (publication orders): orders.florence@unicef.org

Website: www.unicef-icdc.org

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